Initial Intake Form

Murphys Acupuncture and Holistic Medicine

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209-518-4582

Today's date _____/_____/_______
Thank you for taking the time to complete the following form.
All information is confidential. I will happily answer any questions.

General Information

Name____Birthdate______Age______Gender_____
Address_____________________________City____________________State______Zip_______
Phone numbers (please mark * next to best number):
Home__________________________Cell__________________________Work_____________
E-mail address____
Marital Status___________________________# of children ______________________
Their age(s)____
Your Educational level _____________Occupation _____________________Hrs per week_____
Employer & location ____
Health Insurance Co.____
How did you hear about us? ______________________________If via person, name: _________

Emergency Contact

Name______________________________Ph__________________Relationship_____________

Under 18 ---Responsible Party Information

Name____________________________Relationship to Patient___________________________

Healthcare Providers ---please list those you work with

Physicians: GP/Primary Care: ________________________________ seeking one? □ Y □ N
OB-GYN: ____ seeking one? □ Y □ N
Specialist (describe): _______________________________________ seeking one? □ Y □ N
Chiropractor: ____ seeking one? □ Y □ N
Massage Therapist: ____ seeking one? □ Y □ N
Physical Therapist: ____ seeking one? □ Y □ N
Psychotherapist: ____ seeking one? □ Y □ N
Personal Trainer: ____ seeking one? □ Y □ N
Midwife: ____ seeking one? □ Y □ N
Other: ____ seeking one? □ Y □ N
May I contact these providers to ensure coordination of your care? □ Y □ N
Do you have previous experience with acupuncture? □ Y □ N
With whom and results__________________________________

Health History

Please list your major health concerns in order of importance to you:
____
____
____
____

Check those that apply to your past medical history:
☐ Adverse reaction to medical treatment
☐ Alcoholism
☐ Allergies
☐ Arthritis or rheumatism
☐ Asthma
☐ Attempted suicide
☐ Birth Trauma
☐ Bleeding disorder
☐ Blood disease
☐ Cancer or tumor
☐ Diabetes
☐ Emphysema
☐ Eating disorder
☐ Fibromyalgia
☐ Heart disease
☐ Hepatitis/Liver disease
☐ Herpes
☐ High blood pressure
☐ HIV/AIDS
☐ Immune disorder
☐ Joint replacement
☐ Kidney disorder
☐ Low blood pressure
☐ Lyme's disease
☐ Lymph nodes removed
☐ Mental illness
☐ Multiple Sclerosis
☐ Pacemaker
☐ Polio
☐ Rheumatic arthritis
☐ Rheumatic fever
☐ Sciatica
☐ Scarlet fever
☐ Seizures/Epilepsy
☐ Sinus infections
☐ Skin disease/Psoriasis
☐ Special diet
☐ Stroke
☐ Substance abuse
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease/STD
☐ Other____________________

List any serious diseases, injuries, surgeries, or hospitalizations you have had and the year they occurred:

____

____

____

What are your goals for your health?

____

____

____

Please circle your level of commitment to participating in your health? (10 = highest level)
1 2 3 4 5 6 7 8 9 10

Tests and Immunizations

Please list the date of your most recent visit:
Chest X-ray ________ Sigmoidoscopy ________ EKG ________ Stool Blood Test __________
Mammogram ________ TB Skin Test _________ Pap Smear ________ Complete Physical ____
GI Series _________ Flu Shot ___________ Pneumonia Shot _________Other______________

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had (e.g. divorce, injury, family death, bankruptcy, etc).
Date____/______Event____
Date____/______ Event____
Date____/______Event____
Date____/______ Event____
Date____/______Event____
Date____/______ Event____

Family History (List any family physical or mental illnesses and age of death):
Mother____

Father____

Grandparents____

Siblings____

Children____

Medications, Herbs, Supplements (List those you are currently taking):
Name___________________________ Reason __________How long and dose _____________
Name___________________________ Reason __________How long and Dose_____________
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Lifestyle Habits

Describe your typical daily diet:
Breakfast____
Lunch____
Dinner____
Snacks____
Special diet____
Food Allergies____
Does “Organic” or “GMO” factor into your food decisions?_____________________________
Amount and preferred temperature of water____

What is the major source of joy in your life?____

____

____

What is the major source of stress in your life? ____

____

____

Average hours of sleep per night?
Have a supportive relationship?
Have a history of abuse?
Enjoy your work?
Take vacations?
Spend time outside?
Exercise? Describe exercise:
Watch TV? How many hours weekly?
Read Books? How many hours weekly
Computer games/browsing? How many hours weekly
Spiritual/religious practice? Describe:
Smoke cigarettes? How much?
Smoke cigarettes in the past? How many years? How many packs?
Eat out often? How many meals a week?
Drink coffee? How many cups a day? With what added?
Drink tea? How many cups a day? With what added?
Drink soft drinks? How many a day?
Use sugar? How much?
Drink alcohol? How many drinks a week?
Have an addiction? To what and for how long?
Been outside the U.S. in past 12 months? Where?

Please mark the appropriate squares in the following list of symptoms.

If you have had a symptom in the PAST and do not have it now, check the box like this: ☒

If you are having the symptom CURRENTLY, fill in the box like this: ☑

Liver/Gallbladder

□ Depression / Stress
□ Headaches / Migraines
□ Red / Dry / Itchy Eyes
□ Visual Problems / Blurred Vision
□ Dizziness
□ Gall Stones
□ Feeling of Lump in Throat
□ Clenching Teeth at Night
□ Muscle Cramping / Twitching
□ Neck/Shoulder Pain / Tightness
□ Seizures/Tremors
□ Poor Circulation
□ Soft/Brittle Nails
□ Bitter Taste in Mouth
□ PMS/Menstrual Problems
□ Tendonitis
□ Pain Below Ribcage
□ Do you crave: Sour

□ Tend to be Irritable / Angry

Heart/Small Intestine

□ Heart Palpitations
□ Rapid or Irregular Heartbeat
□ Chest Pain
□ High Blood Pressure
□ Low Blood Pressure
□ Insomnia / Sleep Problems
□ Vivid Dreams / Nightmares
□ Easily Startled
□ Dark Urine
□ Red Complexion
□ Do you crave: Bitter
□ Anxiety / Nervous or Restless

Spleen/Stomach

□ Body Heaviness
□ Hard to get up in Morning
□ Muscles Often Feel Tired
Energy Level: 1-10 (low to high) ______
□ Edema (□ Hands □ Feet)
□ Easily Bruising / Bleeding
□ Bad Breath
□ Sweetish Taste in Mouth
□ Lack of Taste
□ Excess or Low Appetite (circle which)
□ Excess or Lack of Thirst (circle which)
□ Nausea / Vomiting
□ Gas / Belching
□ Hemorrhoids
□ Organ Prolapse (i.e. uterus or rectum)
□ Chronic Loose Stools
□ Abdominal Pain
□ Indigestion / Heartburn
□ Brain Foggy
□ Mouth Ulcers
□ Tendency to Gain Weight
□ Do you crave: Sweet
□ Over-thinking / Worry

Lung/Large Intestine

□ Bloody Cough
□ Dry Cough
□ Chronic Cough
□ Cough with Sputum
□ Nasal Discharge
□ White □ Yellow □ Green
□ Post Nasal Drip
□ Sinus Infection / Congestion
□ Itchy, Red, or Painful Throat
□ Dry Mouth / Nose / Throat
□ Skin Rashes / Hives
□ Snoring
□ Shortness of Breath
□ Allergies / Asthma
□ Low Immunity
□ Catch Colds Easily
□ Bronchitis
□ Black or Bloody Stools
□ Constipation

□ IBS
□ Diarrhea
□ Colitis / Spastic Colon
□ Do you crave: Pungent / Spicy
□ Grief / Sadness

Kidney/Urinary Bladder

□ Urinary Problems (i.e. night-time) _______________
□ Bladder Infection
□ Incontinence
□ Weakness / Pain in Low Back
□ Osteoporosis
□ Feel Cold or Hot Easily (circle which)
□ Cold Hands / Feet
□ Low or Excess Sex Drive (circle which)
□ Dark Circles under Eyes
□ Thyroid Problems _________________________
□ Poor Memory
□ Hair Loss / Grey Hair
□ Hearing Problems / Tinnitus
□ Cavities
□ Hot Flashes / Night Sweats
□ Impotence or Premature Ejaculation (circle which)
□ Do you crave: Salt
□ Fear

Confidentiality and Privacy Practices

As a health care provider, we are required by law to maintain and protect the confidentiality of your health information. You must give us written consent to waive this confidentiality. Exceptions to this rule are strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, law enforcement activities, obtaining payment from third-party payers, and in consultation with other healthcare professionals. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. Your rights to privacy regarding your protected health information:

· You may request restrictions on your disclosures.
· You may inspect and receive copies of your records within 30 days with a request.
· You may request to view changes to your records.

Please note that we may contact you for appointment reminders, birthdays & seasonal greetings, announcements and to inform you about our practice and its staff. A more complete description of our privacy practices can be requested.

We are partners in your healthcare.

Your participation in your healing process is crucial. Our goal is to get you well as soon as possible, which requires that you apply our health recommendations and comply with our treatment plan.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her updated on any changes.

Agreement

I have read and understood the clinic's policies. I agree to the all of the above treatment terms and conditions.

Signature: ____

Date: ____